

## Health Alternatives, LLC Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard the information included in your files. We have installed a firewall on our computer; computerized files can only be accessed with a password; and all paperwork is kept in a locked filing cabinet.

**This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.**

### Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

- \* We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
- \* We may disclose your PHI to any third party you designate in writing.
- \* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
- \* We may disclose your PHI if we ever sell or transfer our practice.
- \* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
- \* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
- \* We may disclose your PHI to a health oversight agency for activities authorized by law.
- \* We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
- \* We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
- \* We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
- \* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
- \* We may use or disclose your PHI when required by law.
- \* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

### Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records.
2. You are entitled to make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.

5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HUH Bldg. Washington, DC 20201

Original Effective Date: April 14, 2003

***This notice remains in effect until it is replaced or amended by changes in the law.***

## **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

Law requires the privacy of your health information be maintained and that you are provided this notice of the legal duties and privacy practices with respect to your health information. Other than the uses and disclosures we described below, your health information will not be sold or provided to any outside marketing organizations.

We must abide by the terms of this notice and we reserve the right to change the terms of this privacy notice. If a change is made, it will apply for all of your health information in our files, and you will be notified in writing.

### **HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

#### **USES AND DISCLOSURES**

Here are examples of use and disclosure of your health care information:

1. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your session records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run this practice.
4. We may need to use your name, address, phone number, and your records to contact you to provide appointment reminder calls, recall postcards, Welcome and Thank You cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

#### **YOUR RIGHT TO LIMIT USES OR DISCLOSURES**

You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.

#### **PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT AUTHORIZATION**

Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

1. We are providing services to you based on the orders (referral) of a health care provider.
2. We provide services to you in an emergency and are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

#### **REVOKING YOUR AUTHORIZATION**

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if they decide to contest any of your claims.

#### **CONFIDENTIAL COMMUNICATION**

We will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

**AMENDING YOUR HEALTH INFORMATION**

You have the right to request that we amend your health Information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

**INSPECTING/COPYING YOUR HEALTH INFORMATION**

You have the right to inspect the your files while in our office and/or have a copy made for you. The information is available up to seven years from the date that the record was created. Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of \$.20 per page copied.

**ACCOUNTING OF DISCLOSURES OF YOUR RECORDS**

You have the right to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. The request must be In writing. The accounting will exclude the following disclosures:

Required for your session, to obtain payment for services, to run our practice, and/or made to you.

Necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.

For national security, intelligence purposes, or law enforcement officers.

That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request

**RE-DISCLOSURE**

We cannot control the actions of others to whom we have released your information for further treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

**COMPLAINTS**

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

This notice effective as of April 14, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

I, \_\_\_\_\_ give my permission for you to leave any information for me and use your name/clinic name at the following:

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Fax \_\_\_\_\_

Client Name Printed

Date

Client Signature

Authorized Staff Person

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the client.